



Dept. of Labor and Training
Temporary Disability Insurance
P.O. Box 20100 Cranston RI 02920-0941
APPLICATION FOR BENEFITS

PERSONAL AND WORK INFORMATION																																
I prefer to receive information in: English Spanish Portuguese Your e-mail address: _____							Date of Birth (Month/Day/Year): ____ / ____ / ____ Gender: Male Female Phone Number: ____ - ____ - ____																									
Social Security Number: ____ - ____ - ____ First Name: _____ M.: ____ Last Name: _____ Address: _____ City/Town: _____ State: _____ Zip: _____							If you have recovered and/or returned to work since this illness or injury began, please fill in dates below. Date recovered from illness or injury: ____ / ____ / ____ Date returned to work to reduced hours: ____ / ____ / ____ Date returned to work to normal hours: ____ / ____ / ____																									
Job title (prior to injury or illness): _____ The last day you actually worked before this illness or injury: ____ / ____ / ____ The first workday you were unable to work due to this illness or injury: ____ / ____ / ____ (Note: Dates must correspond to normal work days) During the week in which your last day of work occurred, did you work less than your normal schedule of hours? Yes No If yes , indicate below the gross earnings (before taxes) for the week in which your last day of work occurred . (Our weeks run from Sun. thru Sat.) Include overtime, vacation and sick leave pay; exclude holiday pay if you did not work the holiday. Please indicate below, the hours worked each day during the week in which your last day of work occurred. <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th>Hours Worked</th> <th>Sunday</th> <th>Monday</th> <th>Tuesday</th> <th>Wednesday</th> <th>Thursday</th> <th>Friday</th> <th>Saturday</th> <th>Total Hours</th> <th>Rate of Pay \$</th> <th>Gross Earnings (Before taxes) \$</th> </tr> </thead> <tbody> <tr> <td style="height: 30px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>											Hours Worked	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours	Rate of Pay \$	Gross Earnings (Before taxes) \$											
Hours Worked	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours	Rate of Pay \$	Gross Earnings (Before taxes) \$																						
Check each day you normally work: Sun Mon Tues Wed Thurs Fri Sat Your normal work schedule is: Part-time Full-time Total hours per week: _____ What are your gross wages (before taxes) during one normal/full work week (Sun. thru Sat.): \$ _____ Please select all that applies: Salary Bi-weekly Hourly Per Diem On-Call Commission																																
MEDICAL INFORMATION																																
What is your illness or injury? _____ Is this illness or injury connected to your job? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes , please complete the section on the back page marked "Workers' Compensation Information". Date of your medical examination for this illness/injury, closest to the unable to work date listed above: ____ / ____ / ____ Were you hospitalized for this disability? Yes No Dates admitted to hospital: From: _____ To: _____ Name of Hospital: _____ Address: _____																																
Doctor or Medical Practitioner: _____ Address: _____ City/Town: _____ State: _____ Zip: _____ Phone Number: ____ - ____ - ____					Doctor or Medical Practitioner: _____ Address: _____ City/Town: _____ State: _____ Zip: _____ Phone Number: ____ - ____ - ____																											
BENEFITS HISTORY																																
Have you applied for or received TDI Benefits in the last 12 months? Yes No Have you applied for or received Unemployment Insurance Benefits in the last 12 months: Yes No If yes, the last week ending date you were paid from Unemployment Insurance: ____ / ____ / ____ From which state? _____																																
FOR OFFICE USE ONLY																																
DEP	PHYS	PHYS	DD	SE	WC	UI	BYB	BYE																								

PLEASE COMPLETE BOTH SIDES OF FORM

EMPLOYER INFORMATION- Please include all employers in the last 2 years. To add more employers, attach a separate sheet with your social security number and name at the top.

Employer: _____
 Address: _____
 City/Town: _____ State: _____ Zip: _____
 Phone Number: _____ - _____ - _____
 Employment Dates: ____/____/____ to ____/____/____
 How many hours per week do you normally work? _____
 Was your work performed in RI? Yes No
 Are you a corporate officer, partner or owner? Yes No

Employer: _____
 Address: _____
 City/Town: _____ State: _____ Zip: _____
 Phone Number: _____ - _____ - _____
 Employment Dates: ____/____/____ to ____/____/____
 How many hours per week do you normally work? _____
 Was your work performed in RI? Yes No
 Are you a corporate officer, partner or owner? Yes No

Have you earned wages or performed services through self-employment in the past 2 years? Yes No

List beginning and ending dates of any period of self-employment during the past two years. Employment Dates: ____/____/____ to ____/____/____

DEPENDENTS ALLOWANCE

For how many dependent children do **you provide support** to? _____ (Include children under 18 as well as children 18 and older who are incapacitated.)

List below only the names of children who are your natural, adopted or step children, or are court-appointed wards that you provide support:

(Documentation is required for court appointed wards and children over 18 years of age that are incapacitated.)

Child's First Name	Last Name	Relationship (natural, adopted, step or court ward)	Birth date (mm/dd/yy)	Social Security Number (Required for children 12 months of age or older)

Do you have legal custody of all the children listed above? Yes No
 Do all children listed above live with you? Yes No
 If no, indicate name address and social security number of the person with whom they reside.
 Name: _____
 Address: _____
 Social Security Number: ____/____/____
 If any legal dependent named above is 18 or older, please indicate the type of incapacity (mental or physical).
 Name: _____ Incapacity Type: _____

Is any other person claiming your child/children as dependents under the Rhode Island Temporary Disability Act? Yes No

If yes, indicate the name, address and social security number of the person claiming such children.

Name: _____

Address: _____

Social Security Number: ____/____/____

WORKERS' COMPENSATION INFORMATION- Complete if injury/illness is work connected:

Have you filed a Workers' Compensation claim for this disability? Yes No Date of injury/illness: ____/____/____

Name and address of company where injury occurred:

Name: _____ Address: _____

Have you received any Workers' Compensation payments for this or any other disability? Yes No If yes, dates from: _____ to: _____

If **yes**, please provide the contact information for your Workers' Compensation Insurance Company.

Workers' Compensation Insurance Co.: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

If **no**, please explain why not: _____

If you have a lawyer representing you in this matter, please provide his/her name and address.

Lawyer Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Select Your Preferred Benefit Payment Method:

Select your preferred **payment method** for benefit payments.

☐ Direct Deposit into my account **OR**

☐ Electronic Payment Card (Works like a debit card-EPC)

(You **must** complete the direct deposit form found in the "Forms" folder)

(You may incur fees if card is not used properly)

► SIGNATURE REQUIRED ◀

Certification and Medical Information Release for Rhode Island Temporary Disability Insurance: I certify that I am/was physically unable to work, including self-employment, during the period for which I am claiming benefits, and that the information I have provided on this application is true and complete. Also, I hereby authorize my Qualified Healthcare Provider, hospital or other health care provider to make available to the Rhode Island Temporary Disability Insurance Division any medical information, including hospital records, which may be requested.

Your Signature: _____ Social Security Number: ____/____/____ Date ____/____/____